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December 10, 2002

Stephen J. Alexander, Esquire
Frey, Petrakis, Deeb, Blum, Driggs & Mitts
1601 Market Street 6th Floor
Philadelphia, PA 19103

RE: Lamar Haupt

Dear Mr. Alexander:

As requested by your office, I conducted an independent medical evaluation of Lamar Haupt today. I examined this 48-year-old security officer and former truck driver in the presence of his wife, Carol.

History: He was involved in a motor vehicle accident on July 20, 2000. He was at work, driving his truck and parked at a red light when another truck ran into the back of his truck. His seat broke and he fell backwards into the bunk area, injuring his back.

He went to the Lehighton Hospital on July 22, 2000. He was examined and x-rays were taken. He then saw his family physician, Dr. Diaz, who in turn referred him to Dr. Palumbo. He had physical therapy 5 times weekly in 2000 and then he worked at various times and decreased physical therapy.

He had a series of epidural steroid injections by Dr. Khan, which gave variable temporary relief, for a few days at most.

He started treatment with Dr. Mauthe in July 2001. Initial treatment was with prescription of Gabapentin. He last saw Dr. Mauthe in October 2002. He is not on this medication now. He presently takes Tylenol.

He started work as a security guard in August 2001, and has worked at that occupation since then.

Present Status: He says he has constant low back pain. Tylenol helps. The pain spreads into the left buttock. It is worse after sitting, standing, or walking more than a half hour.

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Review of Systems: Overweight. Unrelated lower limb neuropathy. Hypertension. Spondylolisthesis of longstanding.

Previous Medical History: Back pain since childhood. Treated for many years. Known to have spondylolisthesis many years ago. Low back injury in 1988. Heart attack at about age 30.

Examination: He is 5 feet 9 inches tall and weighs 294 pounds. He is grossly obese with a large pendulous abdomen. There is a slight waddle to his gait. Otherwise, however, the stance and gait are relatively normal and he walks on toes, heels, or inner or outer borders of the feet with normal facility. He also runs in place and performs a deep knee bend and arises.

The cervical and thoracic spine and upper extremities are negative.

Thoracic rotations are 45/45. Lumbar flexion is 80. Extension is 20. Lateral flexions are 25/25. All are smooth and show no segmental restriction. He complains of pain on lumbar flexion. Tenderness is present at T12-L1 and at the mid-lumbar level in the posterior midline. There is no lumbosacral tenderness or deformity and no local step-off is palpable. The Trendelenburg straight leg raising and sitting root tests are all negative.

There is full motion of all joints of both lower extremities. Motor power and deep tendon reflexes are normal and equal. However, there is stocking-like hypesthesia to pinprick of both lower extremities as far up as the upper shin.

Leg lengths are approximately 35-$^1/_2$/35-$^1/_2$ (the anterior superior iliac spines are poorly palpable because of the obesity). Thigh circumferences are 22/22. Calf circumferences are 17/17.

Review of Records: I have reviewed the extensive file of medical records you have submitted to me. These comprise the 13 files listed by you in your letter of December 6, 2002.

Report of S. Palumbo, M.D., on September 11, 2000, describes accident and back pain symptoms. Examination showed tenderness and sensory diminution in the feet.

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MRI was reported as showing spondylolisthesis at L5-S1 and right L4-L5 paracentral disc protrusion. Impression was of lumbar spondylolisthesis.

On September 29, 2000, x-rays of lumbar spine confirmed spondylolisthesis at L5-S1 with instability.

Office note on June 6, 2001, reported recommendation for surgery but the patient declined.

Report of office of Y. Khan, M.D., on September 14, 2000, indicated scheduling for lumbar epidural steroid injection.

Office note on July 24, 2000, described accident.

Emergency room record on July 22, 2002, described accident of July 20, 2000, and pain complaints. X-rays of cervical, thoracic, and lumbar spine were reported as normal. Diagnosis of back and neck sprain.

X-ray of lumbar spine, February 15, 1989, reports spondylolisthesis, L5-S1.

Radiologist's report, July 22, 2000, indicates minimal C3-C4 degenerative changes and spondylolysis, L5-S1. Thoracic spine was negative.

MRI studies of cervical and thoracic spine was unremarkable. MRI of lumbar spine describes spondylolisthesis, L5-S1, and central prolapsed disc at L4-L5 with no impingement.

EMG-NCV on March 8, 2001, appears incomplete.

Initial report of Dr. R. Mauthe, M.D., on July 12, 2001, describes EMG-NCV of March 8, 2001, as being normal. He mentioned many other reports, mostly of MRI studies showing spondylolisthesis. His diagnosis was lumbar spondylolisthesis with an aggravation on July 20, 2000.

His EMG report suggested a "coexisting non-accident related neuropathy." His later reports indicate little change on April 22, 2002.

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He reported an EMG of January 7, 2002, showing lower extremity neuropathy with no evidence of radiculopathy.

IME report of Dr. D. Wukich on August 8, 2001, a diagnosis of spondylolisthesis and central protrusion, L4-L5.

Diagnoses:
1. Spondylolisthesis, L5-S1.
2. Low back strain (July 20, 2000), from history and records.
3. Peripheral neuropathy of lower extremities.

Discussion: This man has had many episodes of low back pain. I relate these to the longstanding developmental spondylolisthesis of L5-S1. This is, in my opinion, a developmental disorder, probably extending from childhood in this man, and the innate instability caused by the spondylolisthesis is, in my opinion, the primary cause and source of the man's complaints. Some element is probably present as well because of his gross and probably morbid obesity with chronic postural back strain and probable minor disc degenerative change.

In my opinion, the accident of July 20, 2000, probably caused a soft tissue injury which can be described as a low back strain. I believe that it did not cause an exacerbation, aggravation, or worsening or the longstanding spondylolisthesis, and I believe that the low back strain probably resolved by the time the man began work as a security guard. Any further episodes of pain would, in my opinion, rather be related to the spondylolisthesis.

I note that this man has a neuropathy, which accounts for his symptoms in his lower extremities. This is, in my opinion, likewise unrelated.

Sincerely,

Edward J. Resnick, MD

EJR:cbs DOD: 12/10/2002 DOT: 12/11/2002